Welcome to the TriHealth Healthy Direction Wellness Program!

Dear Hamilton County Employee:

Hamilton County is promoting wellness services for all employees. To get the new wellness program off to an exciting start, you will receive $150 in your paycheck in February after doing the following:

- ☐ **Complete and sign the Registration Form**
- ☐ **Complete your health risk assessment** at https://wellsuite.com/trihealthcorphealth/trihealthphs/default.aspx?grid=9d7f9b26851a
- ☐ **Schedule an annual preventive physical with your doctor**
  - Your physical must occur between 1/1/2014 and 12/31/2014.

  NOTE: If you have already had your annual preventive physical between 1/1/2014 and 12/31/2014, return to your doctor with the TriHealth packet and have the office staff complete the Biometric Measures and Physical Confirmation Form.
  - If you do not have a doctor – You can select a doctor that is in the Humana health benefit plan network. If you need assistance in finding a physician please go to www.humana.com
- ☐ **Take the TriHealth packet with you to your doctor appointment.**
- ☐ **Have your doctor complete the Biometric Measures and Physical Confirmation Form**
- ☐ **Submit your completed packet at one time by 12/31/2014:**
  - Scan and email to hamiltoncounty@trihealth.com
  - Secure fax 513 852 8595
  - Mail to Katie Krimmer or Mark Walker, 11129 Kenwood Road, Cincinnati, OH 45242

Please keep a copy of all forms for your files.

We will notify you when your packet has been processed. Allow 7-10 business days for that to occur.

Questions about the process?

Please contact us at hamiltoncounty@trihealth.com or contact Katie Krimmer at 977-0020 or Mark Walker and 977-0054.

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Wellness Program Registration Form

PLEASE PRINT CLEARLY

Employer: Hamilton County employee

First Name: _____ Last Name: _____

Date of Birth: __ __/__ __/__ __ __ __ Select One: ☐ Male ☐ Female

Home Address: _____ City: _____ ST: _____ Zip Code: _____

Daytime Phone: _____-_____-_____ Email: _____

My participation in TriHealth Healthy Directions program is voluntary. I understand that the responsibility for initiating a follow-up examination to confirm results of any physical screening and obtain professional medical assistance is mine alone, and not that of my health plan, employer or Bethesda Healthcare, Inc./TriHealth, Inc. Bethesda Healthcare, Inc./TriHealth, Inc. will disclose to my employer that I had a physical, underwent laboratory testing. Bethesda Healthcare, Inc./TriHealth, Inc. will make this disclosure in order for my employer to determine my eligibility for the monetary incentive. My employer will not have access to any of my specific medical information provided under the Healthy Directions Program.

My employer and/or health plan will have access to and review aggregate data (my individually identifiable medical information combined with those of other participants in the Program that does not personally identify me) to assess population trends. I consent to my health plan's/employer's receipt of aggregate data as described in the prior sentence. I further consent to receipt of such aggregate data by my health plan/employer wellness advisor. My health plan/employer will not receive nor have access to my individually identifiable medical information as part of the Program. I further consent to the disclosure of my personally identifiable biometric data/report by Bethesda Healthcare Inc./TriHealth, Inc. to the third party data analytic vendor specified by my health plan/employer in order for such vendor to determine my eligibility for the monetary incentive and/or for data aggregation as described above in this form.

I affirm that I have read, understand and agree to the terms set forth above and I wish to participate in Healthy Directions Program on the terms specified.

_____ _____

*Signature of Participant (REQUIRED) *Date

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Biometric Measures & Physical Confirmation

Participant Name: _____ Date of Birth: _____

Employer Name: Hamilton County employee

- The primary care physician needs to complete all information with an * in front of it.
- All testing must have been completed between 01/01/2014 and 12/31/2014.

BIOMETRIC MEASURES	VALUE	TEST DATE (Month/Day/Year)
*Total Cholesterol		
*Triglyceride Level		
*Glucose (fasting)		
*HDL Cholesterol		
*LDL Cholesterol		
Hemoglobin A1c (if physician recommended)		
*Systolic Blood Pressure		
*Diastolic Blood Pressure		
*Height (in feet, inches)		
*Weight (in pounds)		
*Abdominal Circumference (in inches)		

- *Does your patient have a history of coronary artery disease (MI, CABG, PTCA)? _____yes _____no
- *Does your patient have a history of diabetes? _____yes _____no
- *If no, does your patient have pre-diabetes? _____yes _____no
- *Does your patient exercise weekly? If so, how often? _____ days/week _____ minutes/day

PHYSICAL CONFIRMATION	
Type of Service Provided	*Date of Service
Complete Annual Preventive Physical	_____/_____/_____

_____ _____

*Signature of health care provider *Date

Submit completed packet:

- Scan and email to Hamiltoncounty@trihealth.com
- Send to the secure fax 513 852 8595
- Mail to Katie Krimmer or Mark Walker, 11129 Kenwood Road, Cincinnati, OH 45242

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Healthy Directions Program

Authorization for Use and Disclosure of Protected Health Information

Participant's Name	Employer
Date of Birth	Work Phone Number
E-mail address	

1. Provider Making the Use or Disclosure: I authorize Bethesda Healthcare, Inc. and TriHealth, Inc. (referred to hereinafter collectively as "TriHealth") to use and/or disclose my individually identifiable health information as described below.

2. Recipient of the Information: I authorize, Bethesda Healthcare Inc, TriHealth and the third party data analytics vendor specified by my employer to receive and use the information described below.

3. Type of Information to be Released: I want the following information to be used and disclosed pursuant to this Authorization —

- ✓ Biometric screening results and other medical information contained on the "Biometric Data Reporting" form completed and sent by my physician to TriHealth.
- ✓ Medical information that I provide directly to TriHealth, including biometric data

4. Your Refusal to Sign this Authorization: Trihealth may not condition treatment or health plan enrollment or eligibility for benefits on whether or not you sign this Authorization. If you refuse to sign this Authorization TriHealth will not withhold treatment from you nor will your health insurer condition health plan enrollment or eligibility for benefits.

5. Purpose for the Use or Disclosure: The purpose for the use or disclosure is for my voluntary participation in TriHealth's Healthy Directions Program and in order for TriHealth and/or your employer to make individualized determination of eligibility of the incentive. In addition, TriHealth and/or the third party data analytics vendor specified by my employer will use the information identified above to create and report aggregate (i.e. my data combined with those of other participants that does not personally identify me) information back to my employer or the employer's wellness program advisor, individually identifiable medical information created or received by TriHealth in connection with the Healthy Directions Program will be shared with my employer.

6. Oral Communications: I understand that this Authorization allows TriHealth (and its employees) to discuss my individually identifiable health information described herein with the third party data analytic vendor specified by your employer.

7. Re-disclosure: I understand that the information used and/or disclosed pursuant to this Authorization may be re-disclosed by the recipient of the information and may no longer be protected by Federal law. However, if the information disclosed pursuant to this Authorization includes alcohol or drug treatment records, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from records protected by Federal confidentiality rules (42 CFR part 2). The Federal rules prohibit such person(s) from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the patient to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. If the information disclosed pursuant to this Authorization includes the identity of an individual on whom an HIV test is performed, HIV test results or AIDS-related treatment information, the person(s) receiving such disclosure is hereby notified that this information has been disclosed from confidential records protected from disclosure by Ohio law. Ohio law prohibits such person(s) from making any further disclosure of this information without the specific, written, and informed release of the patient to whom it pertains, or as otherwise permitted by Ohio law. A general authorization for the release of medical or other information is not sufficient for the purpose of the release of HIV test results or diagnoses.

8. Revocation: I understand that I may revoke this Authorization at any time by notifying TriHealth in writing by sending a letter to the address of Bethesda Healthcare, Inc., 11129 Kenwood Road, Cincinnati, Ohio, 45242, addressed to the Coordinator of the Healthy Directions Program I understand that if I revoke this Authorization, it will not affect any actions that TriHealth took before it received my revocation letter.

9. Expiration: This Authorization will expire one year after the date below.

Signature of Participant _____ Date _____

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